Brent Musick, MA, LPC

Supportive Counseling of Tulsa
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CLIENT INFORMATION:

Date:	Name:		Marital Status:
			Single___ Married___ Divorced ___ Widowed ___ Other ___
Date of Birth:	Age:	Gender:	

Home Address (please include Zip for insurance):

Phone:

Cell:
Other:

Email Address:

Emergency Contact:

Name:
Relationship:
Phone #:

Referral Source (How or from whom did you find out about counseling services?):

Current/Previous Mental Health related Medications (medication name, dosage & reason for taking):

Prescribing Physician:

Have you ever been hospitalized for a Mental Health Reason such as suicide attempt, depression, etc? Yes_____ No _____

When?
Where?

Overall Health: (Circle One) Excellent Good Fair Poor

List any changes recently in WEIGHT, APPETITE, IRRITABILITY or SLEEP:

What would you like help with (reason for coming in)?

Client Self Assessment:

Mental Health				
Within the last 60 days (2 months), have you had a significant period in which you have experienced:				
1.	Serious depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your daily activities?	☐ Yes	☐ No	☐ Not Provided
2.	Serious anxiety or tension (felt uptight, worried, and unable to relax)?	☐ Yes	☐ No	☐ Not Provided
3.	Being prescribed medication for psychological/emotional problem?	☐ Yes	☐ No	☐ Not Provided
4.	Thoughts of harming yourself or not wanting to live?	☐ Yes	☐ No	☐ Not Provided
5.	Hallucinations (heard/seen things others don’t hear or see)?	☐ Yes	☐ No	☐ Not Provided
6.	An attempted suicide?	☐ Yes	☐ No	☐ Not Provided

Substance Abuse				
During the past 12 months have you:				
1.	Been preoccupied with drinking alcohol and/or using other drugs/meds?	☐ Yes	☐ No	☐ Not Provided
2.	Tried to stop drinking alcohol and/or using other drugs, but couldn't?	☐ Yes	☐ No	☐ Not Provided
3.	Had problems caused by drinking/using drugs, and you kept using?	☐ Yes	☐ No	☐ Not Provided
4.	Need to drink and/or use more to get the same effect you used to?	☐ Yes	☐ No	☐ Not Provided

Trauma				
During the past year (**12 months**) have you:				
1.	Experienced a traumatic event, natural disaster, war, accident, injury, loss of a loved one?	☐ Y	☐ No	☐ Not Provided
2.	Had periods of time where you felt that you could not trust family or friends?	☐ Y	☐ No	☐ Not Provided
3.	Been afraid of your partner and/or a family member?	☐ Y	☐ No	☐ Not Provided
4.	Ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened?	☐ Y	☐ No	☐ Not Provided
5.	Any past trauma in your **lifetime**? (I will follow you regarding how much you wish to discuss this and when).	☐ Y	☐ No	☐ Not Provided